The Institute of Medicine Report "Unequal Treatment" Ten Years Later

Where we've been, where we are, where we're going…

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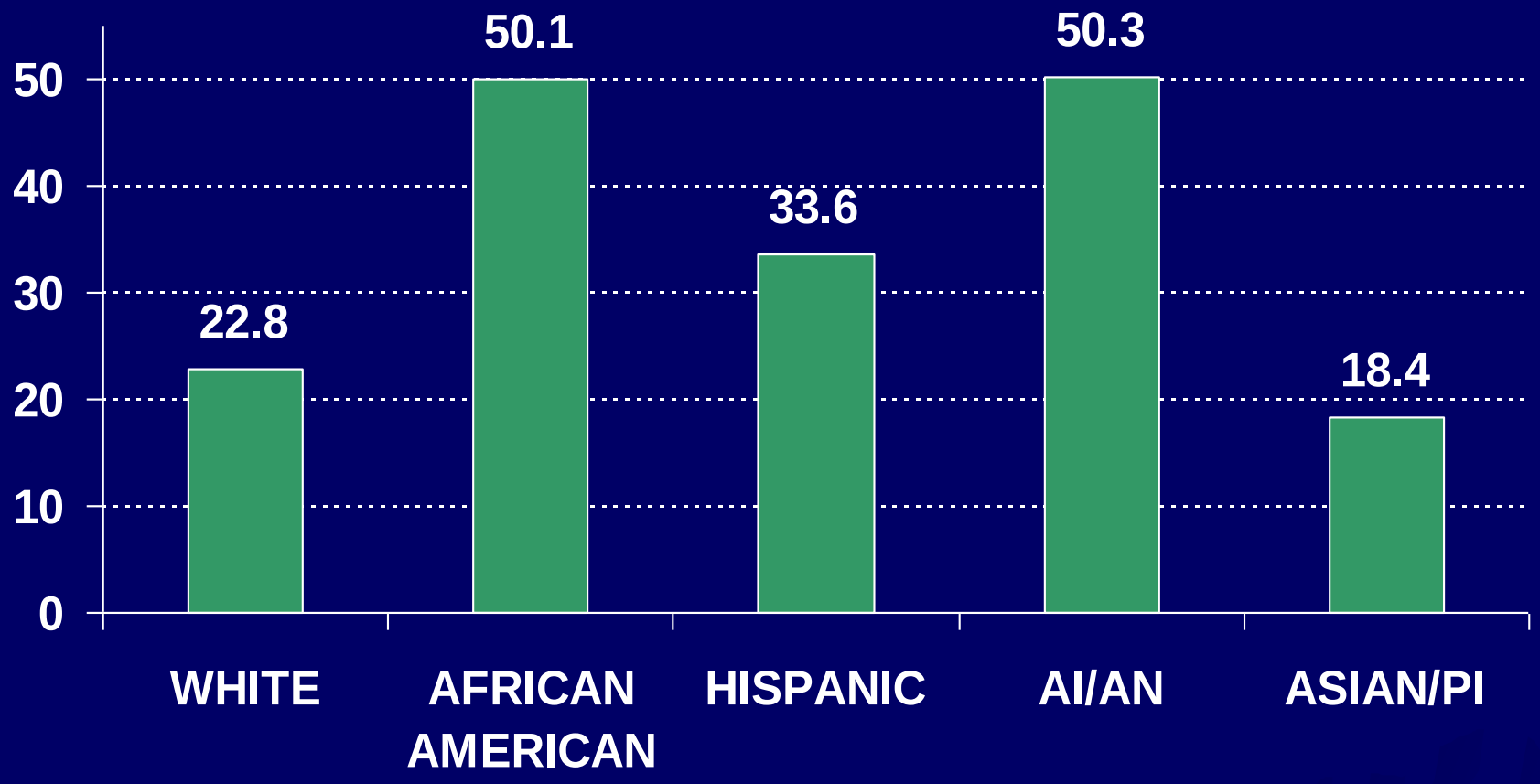
Outline

- Where have we been?
  - Disparities in Health & Health Care, Key Lessons Learned
- Where are we now?
  - Disparities, Quality, Progress to Date, and Implications for Mental Health
- Where are we going?
  - Points of Debate and Key Areas Moving Forward

Where have we been?

Diabetes-Related Death Rate, 1998

Deaths per 100,000 population



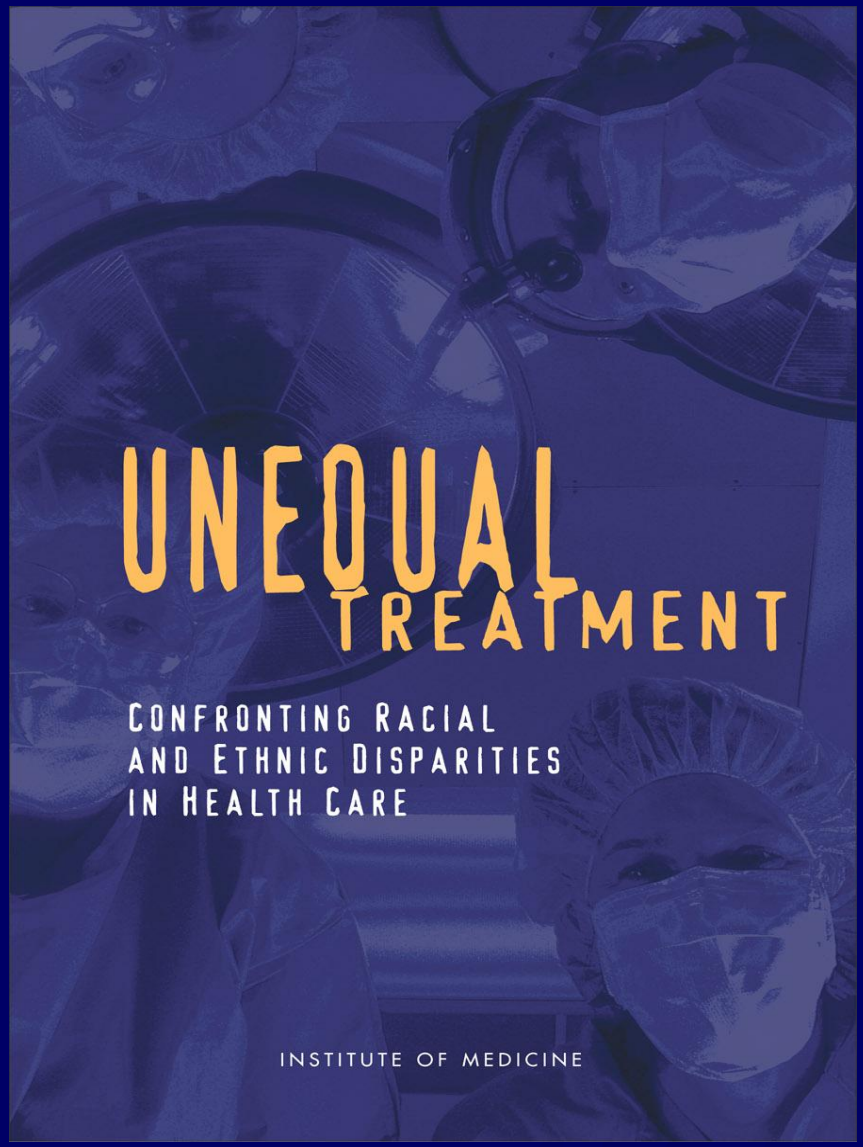
What causes these Racial/Ethnic Disparities in Health?

- Social Determinants
- Access to Care
- Health Care?

Disparities in Health Care *2002*

Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for.

Findings: Many sources contribute to disparities—no one suspect, no one solution



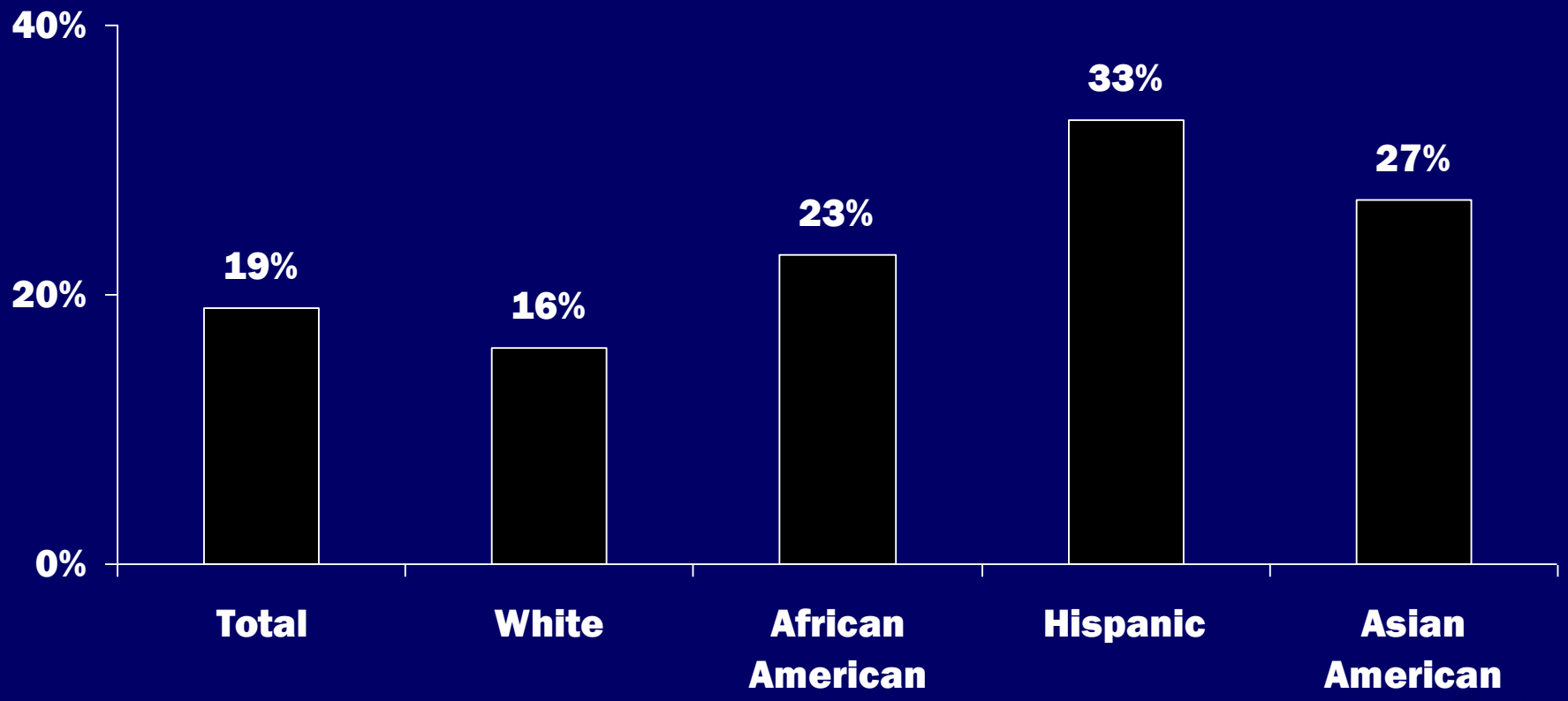
Racial/Ethnic Disparities in Health Care

- Disparities based on race:
  - African-Americans and Hispanics less likely to receive depression treatment during office visits with physicians (Skaer et al., 2000)
  - African-Americans less likely, even with same symptoms, to receive tx recs for depression from physicians (Sirey et al., 1999)
  - After controlling for mult factors, African-Americans less likely to receive mental health specialist services (Harman et al., 2004)

Key Lessons from Unequal Treatment

Minorities Face Greater Difficulty in Communicating with Physicians

Percent of adults with one or more communication problems*



Base: Adults with health care visit in past two years.
* Problems include understanding doctor, feeling doctor listened, had questions but did not ask.

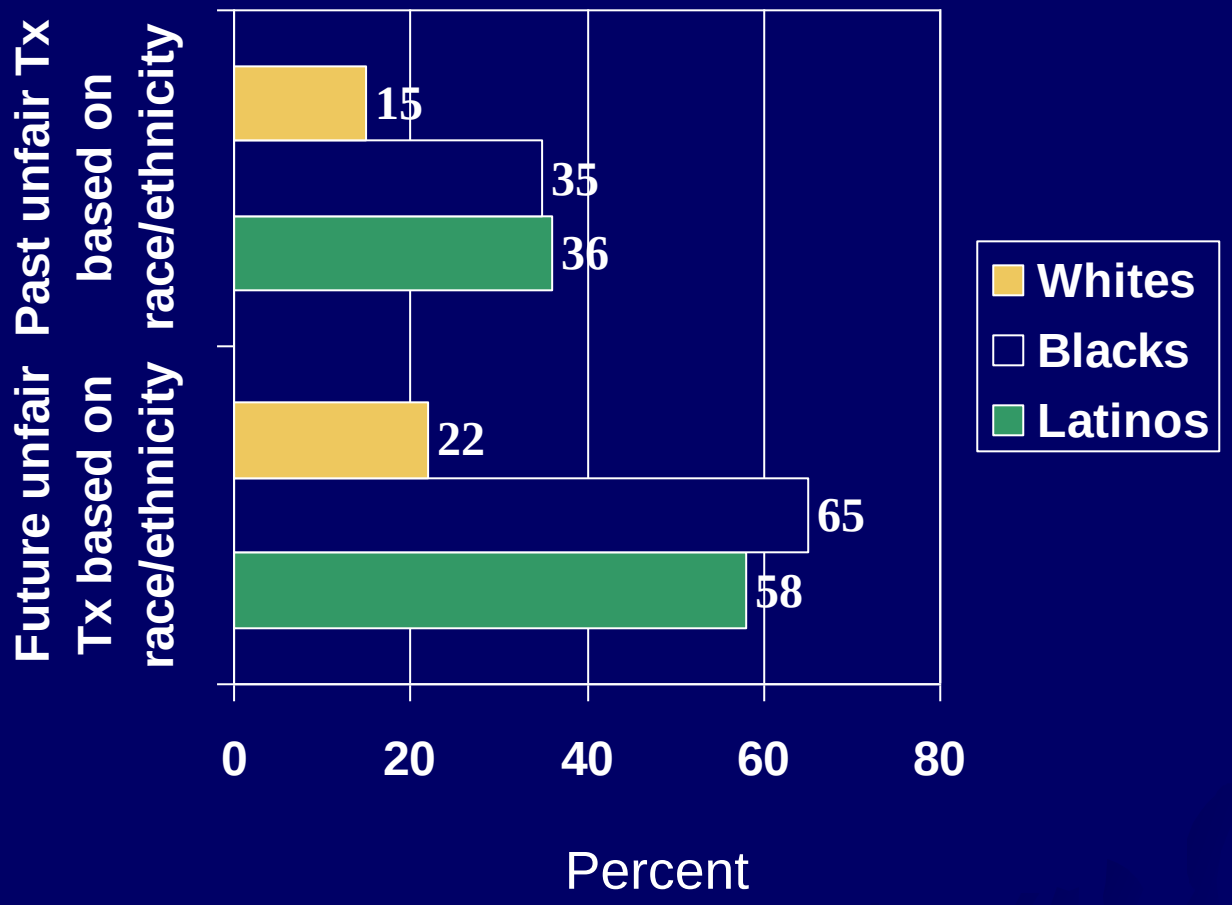
Source: The Commonwealth Fund 2001 Health Care Quality Survey.

Social Cognitive Theory: Stereotyping

- Automatic aspects; group→individual
- "Cognitive Misers"→cognitive shortcuts to save resources; principle of "least effort"
- Primal->race, gender, age
- Activated most when:
  - Stressed
  - Under time constraints
  - Multitasking

The Patient Perspective: Unequal Treatment

Kaiser Family Foundation Survey, 2000



Key Factors Compounded in Mental Health

- System
  - Difficult to navigate;
  - Limited diversity in health care workforce; limited interpreter services;
  - Underpayment, fragmented services
- Provider
  - Difficulty communicating, stereotyping
- Patient
  - Mistrust, stigma, lack of recognition of symptoms

IOM's Unequal Treatment

www.nap.edu

Recommendations

- Increase awareness of existence of disparities
- Address systems of care
  - Support race/ethnicity data collection, quality improvement, evidence-based guidelines, multidisciplinary teams, community outreach
  - Improve workforce diversity
  - Facilitate interpretation services
- Provider education
  - Health Disparities, Cultural Competence, Clinical Decisionmaking
- Patient education (navigation, activation)
- Research
  - Promising strategies, Barriers to eliminating disparities

Addressing Disparities
Progress to Date

- Local Efforts
  - Hospital Committees
  - Work focused on data collection, quality improvement, interpreter services
- State Efforts
  - Statewide Task Forces
  - NJ, CA, WA: CC Legis
  - MA: R/E Data Collection, P4P Measures
- Federal Efforts
  - Legislation stalled, including Kennedy Bill, and Frist's Closing the Gap Act; Frist/Kennedy/Obama Bill
- Private Efforts
  - Purchasers: PBGH, WBGH
  - Health Plans: Aetna, BCBS of Florida
  - Accreditation: NCQA, JCAHO
  - Foundations

Where are we now?

Better Linkage of Disparities to Quality

- Safe
  - Minorities have more medical errors with greater clinical consequences
- Effective
  - Minorities received less evidence-based care (diabetes)
- Patient-centered
  - Minorities less likely to provide truly informed consent
- Timely
  - Minorities more likely to wait for same procedure (transplant)
- Efficient
  - More test ordering in ED for minorities due to poor communication
- Also
  - Minorities have more CHF readmissions, ACS admissions, and longer length of stay for the same condition

Accreditation, Quality Measures, Standards

- Joint Commission
  - New project on culture, health and disparities
  - New disparities/cultural competence accreditation standards 2007, more expected in 2009
- National Committee on Quality Assurance
  - Developed cultural competence standards
- National Quality Forum
  - Developed cultural competence quality measures

Creating an Equitable System

Identifying and Benchmarking Disparities: Progress to Date at MGH

- **Medical Policy**
  - All QI stratified by race/ethnicity
- **Unit-Based Staff Quality Rounds**
  - Exploring potential disparities-causing events
- **Patient Satisfaction**
  - Stratify results by r/e and added questions about respect for culture/race/religion
- **Nat'l Hosp Qual Measures, HEDIS Measures**
  - Stratifying results by race/ethnicity
- **Disparities Dashboard**
  - Report routinely to leadership

Disparities Dashboard

- Executive Summary
  - **Green Light: Areas where care is equitable**
    - Mammography, Pap smear
    - Diabetes measures on campus
    - Core Measures (CAP, AMI, CHF, SCIP)
  - **Orange Light: National disparities, areas to be explored**
    - Mental Health
  - **Red Light: Disparities found, action being taken**
    - Diabetes at community health center
      - Chelsea Diabetes Project
    - Colonoscopy screening rates
      - Chelsea CRC Navigator Program

Key:
- Equal care by race
- Unequal care by race
- Not applicable
- Click on this icon to read an Improvement Story related to this measure

We are including the Core Measures for Heart Attack, Heart Failure and Pneumonia.

Providing Equitable Care

At MGH, we are committed to making sure that all patients, regardless of race, ethnicity, and primary language spoken, receive proper care. Looking at evidence-based measures of care for heart attack, heart failure and pneumonia, there are no significant disparities on how patients are treated. The population we serve at MGH is reflective of the population of the state of Massachusetts. To simplify the table, the information shows results only by race but MGH's performance by ethnicity and language show no statistically significant difference. Read about one of MGH's programs to ensure equal healthcare for all.

Measures	Comparison Group		Equity of Care
Heart Attack	**Race: White**	**Race: Non-white**	
Aspirin at Arrival	99%	100%	=
Aspirin at Discharge	100%	100%	=
Beta Blocker at Arrival	99%	97%	=
Beta Blocker at Discharge	100%	100%	=
ACE-I/ARB at Discharge (AMI)	84%	83%	=
Time to Primary PCI of Less Than or Equal to 90 Minutes	73%	89%	=
Smoking Counseling (AMI)	94%	98%	=
Heart Failure	**Race: White**	**Race: Non-white**	
ACE-I/ARB at Discharge (HF)	82%	86%	=
Discharge Instructions (HF)	63%	65%	=
LVF Assessment	99%	99%	=
Smoking Counseling (HF)	78%	85%	=
Pneumonia	**Race: White**	**Race: Non-white**	
Influenza Vaccination	48%	61%	=
Pneumovax Vaccination	60%	52%	=

System Interventions

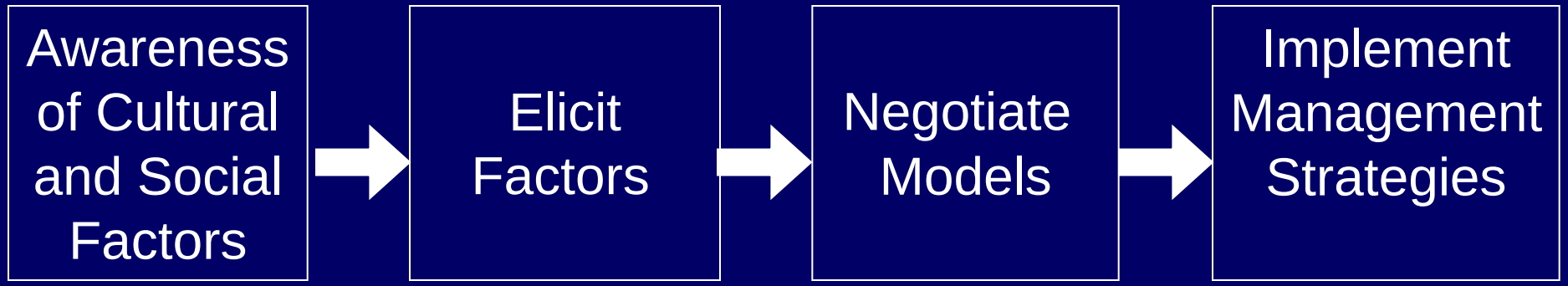
- **Integration of Services and Parity**
  - Minimal success; no wide spread yet
- **Better Distribution of Services, Improved Access**
  - Limited success
- **Pay-for-Performance**
  - Some experimentation with disparities
- **Diversity in Health Care Workforce**
  - Limited success
- **Interpreter Services**
  - Viewed as unfunded mandate; some better than others; tech helping

Patient Interventions

- **Health Coaches**
  - Based at health care delivery site
  - Assist with chronic disease management (ex. Diabetes)
- **Health Care Navigators**
  - Based at health care delivery site
  - Assist with health promotion (cancer screening) and disease prevention (cancer progression)
- **Community Health Workers**
  - Based in community, visit home
  - Assist with chronic disease management (ex. Asthma)

Provider Interventions

- Guidelines
- Detailing
- Cross-Cultural Education



Includes building trust and double-checking clinical decisions to avoid stereotyping

Tools and skills necessary to provide quality care to *any patient* we see, regardless of race, ethnicity, culture, class or language proficiency.

Progress and Implications for Mental Health

Health Disparities Measuring, Monitoring and Tracking in Depression

- **Need to effectively collect race/ethnicity data**
  - MA collects r/e, subgroup, lang, ses (via education), ins status
- **For chronic diseases, diagnosis objective; can then identify cases and track back to quality of treatment**
  - Perhaps more challenging in depression as have to assure diagnosis is appropriately made first
  - Suggests need to standardize screening in cult/ling appropriate way in primary care setting
    - Example is Chelsea Diabetes Program where 50% of patients in program screened positive for depression

Need to develop effective measuring/monitoring/tracking

Health Disparities Interventions in Depression

Van Vorhees et al, MCRR, 2007

Reviewed interventions 1995-2006 w/rigorous criteria

- 20 Studies; 14 RCT's, 8 Observational

- **Chronic Disease Management (Case Mgmt) = 12**
  - Multicomponent most effective in reducing disparities (IMPACT elim disparities, had little cultural tailoring); some interventions used CCM
    - Health care system/provider/patient
    - Navigation/evaluation/initiation of tx/completion of tx/payment
  - Single component ineffective (screening, MD detailing, feedback, educ)
- **Cultural Tailoring = 8**
  - Bilingual providers, lang appropriate materials, case mgmt effective
  - No RCT comparisons

Parallels what is done to address disparities in other areas

Where are we going?

Key Points of Debate

- Will general quality improvement eliminate disparities?
  - Are tailored interventions necessary?
- Can P4P be used as a strategy to address disparities?
  - Might it worsen disparities?
- Is Public Reporting an effective tool?
  - Too contentious?
- Are disparities more due to where patients receive care?
  - Should focus be on improving quality lower quality, primarily minority serving hospitals?

Key Areas Moving Forward

- Evidence supports effectiveness and efficiency of multidisciplinary team approach (Coaches/Navigators, etc)
  - Likely more funding in this area to address disparities
- Health Information Technology attracting great interest and investment; currently exploring capacity to address disparities
  - EMR/PHR/CDM (texting, monitoring)
  - Use of ODL's (doubtful for MD, but likely for Coach/Case Manager)
- Re-Branding of Mental Health
  - "Stress-coping"; "Relaxation-response"; "Mental wellness" emerging from mind-body connection; can possibly diminish stigma among minorities

Policy and Legislation

- Disparities actively being addressed in Health Care Reform
  - Significant implications via payment bundling, readmissions, ACS admissions, never-events (can this affect mental health?)
  - If modeled after MA, will include mandatory r/e data collection, P4P
  - Will likely go farther with funding of workforce recruitment, community based initiatives (coaches, navigators, etc)
- Recommendations related to Mental Health
  - Increase provider payment (primary care being heavily weighed)
  - Increase payment for case management
  - Increase support for diversity in mental health workforce
  - Increase supply of diverse mental health services in MUS areas

Summary

- There is a significant body of evidence that has identified disparities in health care
- Interventions must be developed to address systems, providers and patients
- Addressing disparities will improve the care not only of minorities, but of all Americans